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Clinician's Trauma Update

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Treatment

Does Self-Management Group Therapy work for PTSD? Group therapies are attractive because they are perceived to be cost-effective and well-received by participants. However, there is no strong evidence base showing that group therapy can reduce symptoms of PTSD. There have been relatively few controlled studies (compared with individual therapy) and limited findings, even though almost all studies have used analytic strategies that overestimate the effects of treatment. A recent VA study examined a type of group treatment that is effective for depression, Self-Management Group Therapy (SMT), because depression is often comorbid with PTSD. The investigators randomized 101 veterans to receive either SMT or a psychoeducational group treatment, each meeting 1.5 hours weekly for 14 weeks. The SMT group had lower depression symptoms at the end of treatment ($d = .58$) but not at follow-up. Neither treatment resulted in clinically significant improvements in PTSD or depression. The investigators cited depression severity, PTSD chronicity, and treatment resistance as possible explanations for the findings. However, individual cognitive behavioral therapy can be effective for treating patients with these complexities, so other explanations may need to be considered as well. In contrast to the overall finding in this study (and in line with the persistent popularity of group therapies by

veterans), participants in both groups rated the treatments favorably. This finding is interesting because it shows that the connection between treatment satisfaction and treatment efficacy is not always linear. Studies like this underscore the need for greater understanding of the benefits and limits of group treatments for PTSD.

[Read the article](#)...Dunn, M. J., Rehm, L. P., Schillaci, J., Soucek, J., Mehta, P., Ashton, C. M., Yanasak, E., & Hamilton, J. D. (2007). A randomized trial of self-management and psychoeducational group therapies for comorbid chronic PTSD and depressive disorder. *Journal of Traumatic Stress, 20*, 221-237. PILOTS ID 80924.

Telehealth and the future of PTSD treatment—Using technology to reach veterans: Accessing mental health services has been a long-standing struggle for many veterans. Veterans in rural areas can experience even greater difficulty due to the distance of the nearest VA services. Telehealth may be one solution to this problem. Veterans can gather as a group or come to an individual session and work with a therapist, in real time, by videoconferencing. But is this effective for PTSD? Investigators at the Charleston VA conducted a randomized clinical trial in an effort to answer the question. The investigators randomly assigned 38 male veterans with PTSD to receive 14 weekly 90-minute cognitive-behavioral group sessions, by either videoconferencing or same-room treatment. The data were analyzed using non-inferiority analysis, a statistical technique that is used to determine whether an experimental treatment is inferior to a standard treatment within a margin of error. Change on the PTSD Checklist from before to after treatment was quite small in both groups: a decrease of 2.58 in the same-room group and an increase of 1.78 in the videoconferencing group. According to the non-inferiority analysis, the investigators could be 95% confident that videoconferencing was not inferior by no more than 12.9 units at the end of treatment and 7.2 units at 3-month follow-up. (Smaller is better, and these values are somewhat large.) Groups did not differ in session attendance and satisfaction with treatment, but the same-room group was more likely to complete assigned homework and report greater comfort with talking with their therapist. Thus, despite some advantages of same-room format, these results provide preliminary support for use of videoconferencing in PTSD treatment. Perhaps the most important question is not whether telehealth is effective, but rather, how can we make it optimally effective to maximize the provision of services to veterans who have difficulty accessing care.

[Read the article](#)...Frueh, B. C., Monnier, J., Yim, E., Grubaugh, A. L., Hamner, M. B., & Knapp, R. G. (2007). A randomized controlled trial of telepsychiatry for post-traumatic stress disorder. *Journal of Telemedicine and Telecare, 13*, 142-147. PILOTS ID 29644.

Can acupuncture reduce symptoms of PTSD? Acupuncture has been reported to be effective for treating symptoms that often occur in PTSD patients, including depression, anxiety, and insomnia. The effects of acupuncture are thought to be mediated by systems involved in the pathophysiology of PTSD, including the autonomic nervous system, prefrontal and limbic areas of the brain, and opioid system. However, until recently, there had been no published randomized clinical trial of acupuncture for treating PTSD. In a new study, investigators randomly assigned 84 men and women with PTSD to receive acupuncture or cognitive-behavioral group therapy, or to a waiting list. Eleven patients

dropped out before any data could be collected to use for intention-to-treat analysis, resulting in an actual sample size of 73. Acupuncture was conducted in 12 1-hr sessions twice a week. Group therapy was conducted in 12 2-hr weekly sessions. The two treatments did not differ in their effectiveness for PTSD, depression, anxiety, or functional impairment. Both were better than waitlist, and both resulted in improvements at the end of treatment and at 3-month follow-up. These results are encouraging, but should be interpreted with some caution. Acupuncture was administered by one practitioner only, and the research coordinator who collected the data was not blind to treatment assignment. Also, novel interventions may be especially affected by demand characteristics, so further study using additional controls (such as a comparison group that receives sham acupuncture) is needed. Nevertheless, the investigators have made a substantial contribution to moving the science in this area forward.

[Read the article](#)...Hollifield, M., Sinclair-Lian, N., Warner, T. D., & Hammerschlag, R. (2007). Acupuncture for posttraumatic stress disorder: A randomized controlled pilot trial. *Journal of Nervous and Mental Disease*, 195, 504-513. PILOTS ID 29609.

OIF/OEF Veterans

No gender differences in PTSD among UK military personnel: The expanded role for women in the military has led to increasing questions about whether women have higher risk than men for developing PTSD. In civilian samples, the risk of PTSD is typically twice as high among women. Findings for military personnel have been inconsistent. Direct gender comparisons have been difficult to make because men and women often have such different types of traumatic exposure even when deployed. A report from the United Kingdom provides new information on military samples from recent conflicts in which exposure for men and women is more similar than in prior conflicts. The investigators studied two random samples of UK military personnel, a Gulf War sample drawn in 1997 and an Iraq sample drawn between 2004-2006. There were few gender differences among both deployed and nondeployed personnel within each sample. Women were at increased risk of general psychological distress and fatigue, but did not differ from men in posttraumatic stress reaction (defined according to a measure developed for this study), or in physical symptoms, alcohol use, or general health perceptions. A comparison of the Gulf War and Iraq samples to examine trends over time indicated some differences by gender. In men, there was a *decrease* over time in posttraumatic stress reaction only among *deployed* personnel. In women, there was an *increase* over time only among *nondeployed* personnel. The time trends are difficult to interpret because of numerous differences among the samples and the study methodology at each time. However, it is helpful to know that there may not be increased risk of PTSD among women serving in a warzone, despite their increased exposure to combat stressors.

[Read the article](#)...Rona, R. J., Fear, N. T., Hull, L., & Wessely, S. (2007). Women in novel occupational roles: Mental health trends in the UK Armed Forces. *International Journal of Epidemiology*, 36, 319-326. PILOTS ID 29646.

(See the following story for more information about US military personnel.)

No differences in PTSD among OIF/OEF personnel either: As indicated in the prior story, the risk of PTSD among women is elevated in civilians, but results have been much less consistent among military and veteran samples—no doubt in part to the differences between men and women in warzone exposure. The absence of a defined front line for the conflicts in Iraq and Afghanistan means that even personnel assigned to noncombat or combat support roles can be extensively exposed to combat stressors. Consequently, women are increasingly exposed to stressors more traditionally experienced by men in combat roles, making gender comparisons more interpretable. A published commentary on the study of gender differences in UK military personnel by Rona et al. (2007) reports a similar absence of gender differences among US forces serving in OIF/OEF. In a sample of 708 support troops, the prevalence of PTSD was 11.0% in men and 12.4% in women. The men and women had similar combat experiences, except that women were more likely to have handled human remains (38% vs. 29%) and men were more likely to have been in firefights (47% of men vs. 36% of women reported receiving small arms fire, and 15% of men vs. 7% of women reported firing at the enemy). The investigators hypothesize that the intensity of the warzone stressors in Iraq equalizes the risk of PTSD among men and women. This could be seen as a glass half full—women are not at higher risk—or as one half empty, if the high intensity exposure elevates risk among both men and women. Continued study of separated personnel is needed to determine whether the absence of gender differences persists when men and women return to civilian life.

[Read the article](#)...Hoge, C. W., Clark, J. C., & Castro, C. A. (2007). Commentary: Women in combat and the risk of posttraumatic stress disorder and depression. *International Journal of Epidemiology*, 36, 327-329. PILOTS ID 29647.

Readjustment and relationship difficulties help to explain elevations in PTSD symptoms in UK reserve forces deployed to Iraq. Increased numbers of reservists in the UK deployed to Iraq have raised concern about their ill health upon return. Deployed reservists have worse health outcomes and more mental health disorders than both regular military personnel who are deployed and non-deployed reservists. However, little research has been done to determine why deployment has such relatively greater effects on reserve forces. A recent questionnaire study in the UK of 4,722 military personnel deployed to Iraq and 5,550 nondeployed personnel attempted to address this question. As expected, reservists had more negative health outcomes than regular forces. They were 50% more likely than regular military personnel to be categorized as having PTSD, although the difference was small in absolute terms: 6% vs. 4%, respectively. The reservists also reported more problems at home during and after deployment. For most outcomes, the higher amount of problems experienced by the reservists was explained by role, traumatic exposure, and unit cohesion. PTSD was an exception, with problems at home additionally helping to explain the difference between reservists and regular military personnel. Although interpretation is limited by the cross-sectional nature of the study, this finding is important because it highlights the complicated interplay of family functioning, social support and PTSD. Family issues—a potential concern for all deployed forces—may need particular attention in the prevention and treatment efforts with reservists.

[Read the article](#)...Browne, T., Hull, L., Horn, O., Jones, M., Murphy, D., Fear, N. T., Greenberg, N., French, C., Rona, R. J., Wessely, S., & Hotopf, M. (2007). Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. *British Journal of Psychiatry*, 190, 484-489. PILOTS ID 29597.

PTSD in Primary Care

New information about PTSD screening instruments: With the return of increasing numbers of OIF/OEF veterans and greater awareness of the prevalence of PTSD in primary care patients, detecting the presence of PTSD has been a major focus of VA care. Screening for PTSD in primary care is an essential component of detection and can lead to timely and appropriate interventions that decrease symptoms and improve quality of life. Researchers recently evaluated the performance of two screening instruments, the 17-item PTSD Checklist (PCL) and the 4-item SPAN (a brief screen developed by Duke University), in an effort to enhance PTSD diagnostic accuracy in primary care settings. The investigators recruited 840 patients from 4 VA primary care clinics to compare the PCL and SPAN with the Clinician Administered PTSD Scale (CAPS), the gold standard in PTSD assessment. Overall presence of PTSD as defined by the CAPS was 11.3%. Receiver Operating Characteristic analysis indicated that a cutoff score of 31 on the PCL provided an ideal balance between sensitivity (81%) and specificity (81%). The optimum cutoff score for the SPAN remained the same as that already recommended: 5 (sensitivity 74% and specificity 82%). Performance of the instruments did not differ according to patients' race or sex, except that the PCL performed somewhat better among Caucasians than among African-Americans for veterans under age 50. Overall, the PCL performed better than the SPAN. There are two important considerations given these data. First, the PCL is recommended over the SPAN. Second, recommended cutoff scores for the PCL have ranged from 30-50. This study suggests that a relatively low score may be optimal for screening in primary care, where sensitivity is needed to find cases but specificity is important so that busy clinicians are not overwhelmed by false positives.

[Read the article](#)...Yeager, D. E., Magruder, K. M., Knapp, R. G., Nicholas, J. S., & Frueh, B. C. (2007). Performance characteristics of the Posttraumatic Stress Disorder Checklist and SPAN in Veterans Affairs primary care settings. *General Hospital Psychiatry*, 29, 294-301. PILOTS ID 29645.

Do we go far enough in detecting and treating PTSD in depressed primary care patients? The increased focus on PTSD in primary care populations has been accompanied by increasing recognition that PTSD is a common comorbid condition in patients identified as being depressed. The comorbidity may have important implications for treatment, especially if PTSD is actually the primary disorder. In order to understand more about the comorbidity between depression and PTSD, a group of investigators used data from 677 patients at 10 VA primary care clinics. The patients, who were screened for enrollment in a randomized clinical trial of integrated care for depression, met criteria for major depression on the PHQ-9 and had at least one primary care visit in the last year. According to the 4-item Primary Care PTSD screen, 36% of the depressed patients had probable PTSD. Patients with comorbid PTSD differed from patients with depression alone in a number of

important areas. The patients with PTSD had more severe depression, more anxiety, panic, and suicidal ideation, greater health care utilization, and lower social support. The greater complexity of patients with comorbid PTSD suggests a need to address this complexity in treatment and practice guidelines. For instance, depression may respond differently to standard interventions if PTSD is also diagnosed (e.g., longer time to remission, worse short-term outcomes, increased risk, etc.). Different levels of stepped care or streamlined referrals may be more appropriate for this population.

[Read the article](#)...Campbell, D. G., Felker, B. L., Liu, C., Yano, E. M., Kirchner, J. E., Chan, D., Rubenstein, L. V., & Chaney, E. F. (2007). Prevalence of depression-PTSD comorbidity: Implications for clinical practice guidelines and primary care-based interventions. *Journal of General Internal Medicine*, 22, 711-718. PILOTS ID 29643.

Utilization

How does filing a PTSD disability claim affect treatment utilization? A rise in PTSD disability claims filed by veterans over the past several years has focused attention on the application process itself, as well as on the relationship between filing a claim and treatment participation. Concerns have been raised that some veterans engage in treatment only up to the point of pursuing a successful claim, dropping out once they receive an award. However, we know little about the complex interplay between treatment-seeking and claim-seeking. We need to understand what actually happens when veterans file a claim. A recent study of 922 veterans applying for PTSD disability compensation at the Minneapolis VA offers important insights and provides some answers. The investigators used administrative databases to examine the mental and medical healthcare use during the preapplication, claim, and postnotification periods of the claims process. Utilization increased during the claims process. The claims decision was important in determining utilization during the postnotification period. Veterans whose claims were denied decreased their participation in mental health treatment to preapplication levels. In contrast, veterans whose claims were approved continued to participate in mental treatment at a rate higher than they had before filing a claim. These veterans also had been more likely than veterans whose claims were denied to have participated in mental health treatment before filing a claim. The investigators suggest that participation in the disability claim process might both enhance and be enhanced by participation in mental health treatment.

[Read the article](#)...Spoont, M. R., Sayer, N. A., Nelson, D. B., & Nugent, S. (2007). Does filing a posttraumatic stress disorder disability claim promote mental health care participation among veterans? *Military Medicine*, 172, 572-575. PILOTS ID 80954.

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